Item 9 FilmC151 2/20/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01187

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 53 East St

3. NAME OF DECEASED (Type or Print): (First) Maria (Middle) Gracie (Last) Alvino
4. DATE OF DEATH: (Month) Feb (Day) 14 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W		6-19-1863	~~90~~ 89 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carmine Minnette
14. MOTHER'S MAIDEN NAME: U N K.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Mrs Carmine Pistacco

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Coronary occlusion	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	7 yrs.
	(c) Arteriosclerotic Heart Disease	7 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-7, 1953, to 2-14, 1953, that I last saw the deceased alive on 2-14, 1953, and that death occurred at 9⁰⁰ p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James R. Martin	M.D.	Annapolis, Md.	2-16-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-17-53	Mount Moriah Cemetery	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 16, 1953	H. O. Council B.W.	John M Taylor & Son	Annapolis, Md

RECEIVED
FEB 18 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01188

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood (Post Office) — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS All Hallows-Birdsville

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood Post Office
STREET ADDRESS (If rural give location) All Hallows- Birdsville

3. NAME OF DECEASED: (Type or Print) (First) BENJAMIN (Middle) GOTT (Last) BEARD

4. DATE OF DEATH: (Month) FEBRUARY (Day) 16 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 7, 1883

9. AGE last birthday: 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Dairy Farm Owner

11. BIRTHPLACE (State or foreign country): Prince George County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dr. Stephen Beard

14. MOTHER'S MAIDEN NAME: Amo Gott

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Sallie Collinson Beard Wife Same as 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.1

Immediate cause (a) Coronary Occlusion

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Genial arteriosclerosis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 49 to Feb 16, 19 53, that I last saw the deceased alive on Feb 16, 19 53, and that death occurred at 9:43 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M.D. — ADDRESS Cattrain, Md. — DATE SIGNED 2-16-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-18-53 — NAME OF CEMETERY OR CREMATORY All Hallows Cemetery — LOCATION (City, town, or county) (State) Birdsville, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 18, 1953 — REGISTRAR'S SIGNATURE H. C. Clayton Deputy Reg

24. FUNERAL DIRECTOR — ADDRESS Ben L. Hopping and Son Annapolis, Md.

VS. A15

RECEIVED
FEB 24 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01189

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Anarundel Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Best Gate; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mercy (Middle) (Last) Bell

4. DATE OF DEATH: (Month) Feb (Day) 10 (Year) 1953

5. SEX: female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH: Mar. 11, 1878

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Gen Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: M. Butler, Best Gate, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Diabetes Mellitus — 1 Mon.+

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10, 1953, to 2/10, 1953 that I last saw the deceased alive on 2/10, 1953, and that death occurred at 10:25 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M Shipley M.D. Annapolis 2/11/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb. 13, 1953 — NAME OF CEMETERY OR CREMATORY Fowlers — LOCATION (City, town, or county) (State) A.A. Co. Best Gate Md

DATE REC'D BY LOCAL REGISTRAR Feb. 12, 1953 — REGISTRAR'S SIGNATURE B.S. — 24. FUNERAL DIRECTOR — ADDRESS J.B. Johnson Annapolis, Md.

VS. A15

RECEIVED
FEB 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01190

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 522 Sixth St.

3. NAME OF DECEASED (Type or Print): (First) ROLAND (Middle) PAUL (Last) BELL
4. DATE OF DEATH: (Month) 2 (Day) 17 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married
8. DATE OF BIRTH: Apr. 25-1909
9. AGE last birthday: 44 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Masonry Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Eastport Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Norman R. Bell
14. MOTHER'S MAIDEN NAME: Edith D. Stevens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Marjorie E. Bell Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-17, 1953, to 2-17, 1953, that I last saw the deceased alive on 2-17, 1953, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
George C Bosie M D Annapolis Md 2.19.53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2-20-53 | NAME OF CEMETERY OR CREMATORY St James Cemetery | LOCATION (City, town, or county) Fothian (State) Md.

DATE REC'D BY LOCAL REG. Feb 20, 1953 | REGISTRAR'S SIGNATURE P.W | 24. FUNERAL DIRECTOR John M. Taylor & Son | ADDRESS Annapolis Md.

RECEIVED
FEB 24 1953
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01191 22

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel, Maryland
LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D. C.
STREET ADDRESS (If rural, give location) 2309 - 18th St., S.W.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) none (Last) Bennett
4. DATE OF DEATH: (Month) 2 (Day) 27 (Year) 19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Single	11-3-44	8 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inmate
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Bennett
14. MOTHER'S MAIDEN NAME: Vivian Curry Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Records D.T.S. & Staff, Laurel, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
325.1 Immediate cause	(a) Broncho Pneumonia (bilateral)	48 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epileptic	Life
	(c) Microcephalic Idiot	Life
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Mental deficiency	

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/13, 19 49, to 2/27, 19 53, that I last saw the deceased alive on 2/26, 19 53, and that death occurred at 2:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
B Kludat M.D. Med. Officer D.T.S. Laurel, Md. 2/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Mar 2-53 NAME OF CEMETERY OR CREMATORY Washington LOCATION (City, town, or county) D C (State)

DATE REC'D BY LOCAL REG. Feb 27-53 REGISTRAR'S SIGNATURE Clara Haslup
24. FUNERAL DIRECTOR ADDRESS W Ernest Harris 1432 (now) N W

RECEIVED
MAR 5 1980
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1192

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8-715 8-51

1. PLACE OF DEATH:
COUNTY A A — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. G. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chesapeake City
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) (Last) BENSON

4. DATE OF DEATH: (Month) Feb (Day) 21 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: July 5, 1876

9. AGE last birthday: 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY: Trucking Business

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Benson

14. MOTHER'S MAIDEN NAME: Elizabeth Denney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Kate Benson Chesapeake City, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

420.0
Immediate cause (a) Coronary Thrombosis — 8 hrs.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Arteriosclerotic Heart disease — unknown
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — unknown

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** — **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) M. OF INJURY — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6:30 am to 2:30 pm. 2-21-53, 19..., to ..., 19..., that I last saw the deceased alive on 2-21, 1953, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
George C Bozel M.D. Annapolis Md — 2.21.53

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF 2/24/53 — NAME OF CEMETERY OR CREMATORY Bethel Cemetery — LOCATION (City, town, or county) (State) Chesapeake City Md.

DATE REC'D BY LOCAL REG. Feb 21, 1953 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR H. W. Pippin & Son — ADDRESS Elkton, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. (1953) 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Glen Burnie

LENGTH OF STAY (in this place): 2 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Point Pleasant

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Same — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Agnes (Last) Bland

4. DATE OF DEATH: (Month) Feb. (Day) 14 (Year) 1953

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 12/17/[illegible]

9. AGE last birthday: 75 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Georges R. Ludlan

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 577-05-2467

17. INFORMANT & ADDRESS: Mr. Edward Bland (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General Arteriosclerosis. — 2 y.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 52, to Feb. 14, 1953., that I last saw the deceased alive on 2/12/53 19....., and that death occurred at 11:45 P.m., from the causes and on the date stated above.

SIGNATURE Gertrude A. Pearce M.D. (DEGREE OR TITLE) ADDRESS Glen Burnie, Md. DATE SIGNED 2/15/53

23. BURIAL, CREMATION REMOVAL (Specify): B

DATE THEREOF 2/18/53

NAME OF CEMETERY OR CREMATORY Mt Olivet

LOCATION (City, town, or county) Washington DC (State)

DATE REC'D BY LOCAL REG. 2/15

REGISTRAR'S SIGNATURE L. J. Dillon

24. FUNERAL DIRECTOR Robert A. Mattingly ADDRESS 131 - 11th St. N.W. DC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. 415 5-51

1. PLACE OF DEATH:
COUNTY Frederick Md — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Freetown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) James S. (Middle) (Last) Boddy

4. DATE OF DEATH: (Month) 2 (Day) 1 (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	col	W	1-31-	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Boddy
14. MOTHER'S MAIDEN NAME: Hinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Georgiana Boddy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary Thrombosis	1 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Congestive Heart Failure	4 weeks
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1953, to Feb. 1, 1953, that I last saw the deceased alive on Jan. 31, 1953 and that death occurred at 3:25 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
Randall M. McLaughlin M.D. Pasadena. Md. Feb. 1, 1953

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/5/53	~~Bur~~ Hall Churchyard	A A Co. Md

DATE REC'D BY LOCAL REG. 2-4-53 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS
Isaiah L Brown Son 1084 Montgomery St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 02329

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 4yrs 4m 8days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 654 H. Mulberry Street

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) (Last) Carter

4. DATE OF DEATH: (Month) Feby (Day) 7th (Year) 1953

5. SEX: M

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: March 3, 1877 1882.

9. AGE last birthday: 57 70 yrs. IF UNDER 1 YEAR Months 10 Days IF UNDER 24 HRS. Hours 6 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Butcher's helper

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel M Carter

14. MOTHER'S MAIDEN NAME: Isabella Brooks

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs Estelle Owings 1102 N Caulton Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized arteriosclerosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: Long time ado

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 29th, 1948, to Feby. 7th, 1953, that I last saw the deceased alive on Feby. 7th, 1953, and that death occurred at Feby 7th 7:45 pm from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold V. Eckert M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Feb 11/53 NAME OF CEMETERY OR CREMATORY Antietam Mem Park LOCATION (City, town, or county) Antietam (State) Md

DATE REC'D BY LOCAL REGISTRAR 2-11-53 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Joseph L. Russ ADDRESS 2222 W. North Ave

Duplicate.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 195

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Waugh chapel Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
STREET ADDRESS (If rural, give location): Waugh Chapel Rd

3. NAME OF DECEASED: (First) Martha (Middle) Kate (Last) CLARK

4. DATE OF DEATH: (Month) FEBRUARY (Day) 12, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: December 12, 1865

9. AGE last birthday: 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Brooklyn, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MosesDonaldson

14. MOTHER'S MAIDEN NAME: Matilda Sansbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mr Myron Clark Gambrills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0

Immediate cause — (a) Arterio sclerotic Heart Disease — Interval Between Onset and Death: 2 Years

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Generalized Arterio - Sclerosis — 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

INJURY OCCURRED: While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 19 46, to Feb 12, 19 53, that I last saw the deceased alive on Feb 11, 19 53, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Edward J Schmidt M.D. — ADDRESS Gambrills Md — DATE SIGNED Feb 13, 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 15, 53 — NAME OF CEMETERY OR CREMATORY: Trinity Cemetery — LOCATION (City, or town, county) (State): Patuxant, A.A. Co., Md.

DATE REC'D BY LOCAL REG. 2-13-53 — REGISTRAR'S SIGNATURE: K M Joyce

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.

FEB 13 1973

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

61 96

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shoreland Drive & Pt. Pleasant

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) P. O. 136 " Route "

3. NAME OF DECEASED (Type or Print): (First) Mertice (Middle) (Last) Cole
4. DATE OF DEATH: (Month) 2 (Day) 1 (Year) 19 53
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Apr. 10, 1882
9. AGE last birthday: 70 yrs. If under 1 year: Months Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Packer
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frederick W. Cole
14. MOTHER'S MAIDEN NAME: Sophie Cooke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr. Carl Schemmel, Shore Land Drive Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause (a) Cerebral Vascular Accident

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular Dis.

(c) Arterio - sclerosis.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-29, 1952; to 1-20, 1953, that I last saw the deceased alive on 1-20, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William H. McDonald M.D. 204 Crain Hwy. Glen Burnie 2-1-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 2/10/53
NAME OF CEMETERY OR CREMATORY: Loudon Pk.
LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 2-13
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: Wm. J. Tuckner Sons Inc ADDRESS: Balto. md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1953

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 8-51

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Annapolis

LENGTH OF STAY (in this place):

HOSPITAL OR ~~INSTITUTION OR STREET ADDRESS~~: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: — COUNTY: A.A.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chalk Point

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
ELLA	ELIZABETH	CRANDALL	2	4	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Mln.
F	White	widowed	Aug. 12	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Tavern owner	Tavern	Shady Side, Md	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Serge H. Placide	Maggie P. Kirchner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT'S ADDRESS:
NO	NO	Gordon A. Crandall, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
331X Immediate cause	(a) Cerebral Vascular Accident	4 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis, generalized	indefinite
DUE TO		
(170X)	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Extensive Metastatic Carcinoma of Breast — 4 years

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 June, 1953, to 4 Feb., 1953, that I last saw the deceased alive on 4 Feb., 1953, and that death occurred at 1 A.M. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Edward J. Beck	MD	41 Southgate Ave. Annapolis	5 Feb 53

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/6/53	Woodfield	Galesville, A.A.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 5, 1953	[signature]	J.A. Hardesty & Son	Galesville

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01199 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS. 415

1. PLACE OF DEATH:
COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McKendree
MARYLAND
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md
COUNTY aa
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN McKendree
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Nelson (Middle) Reed (Last) Crandell

4. DATE OF DEATH: (Month) 2 (Day) 2 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Mar

8. DATE OF BIRTH: Aug 20 1885

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farmer (Tobacco)

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Crandell

14. MOTHER'S MAIDEN NAME: Verna Wagon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Nelson Crandell Jr -McKendree, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary embolism

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hepatitis

DUE TO

(c)

Interval Between Onset And Death: 2 mos

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Found dead in bed

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10 ,1952 to 2/2 ,1953, that I last saw the deceased alive on 1/29 ,1953, and that death occurred at 6.45 A.M., from the causes and on the date stated above.

SIGNATURE Howard Crandell (Degree or title) ADDRESS McKendree DATE SIGNED 2/2/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 2/5/53

NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist

LOCATION (City, town, or county) Lothian (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 2/5/53

REGISTRAR'S SIGNATURE W. I. Clayton

24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (In this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Delaware — COUNTY New Castle
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wilmington
STREET ADDRESS (If rural, give location) Rockland (rural)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Louise (Last) Culley
4. DATE OF DEATH: (Month) February (Day) 19 (Year) 19 53

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant
8. DATE OF BIRTH: 21 Nov 1952
9. AGE last birthday: yrs. — If under 1 year: Months 2, Days 29 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Corlett Culley
14. MOTHER'S MAIDEN NAME: Louise Margaret Decino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Cpl John Culley (same as #2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subendocardial Fibroelastosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN): —
(COUNTY)
(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
INJURY OCCURRED While at Work [ ] Not While At work [ ]
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 19 Feb, 1953, to 19 Feb, 1953, that I last saw the deceased alive on 19 Feb, 1953, and that death occurred at 1010 A.m., from the causes and on the date stated above.

SIGNATURE: Mary C. Leinheimer (Degree or title) Lt. MC ADDRESS: U.S. Army Hospital, Ft. Meade, Md. DATE SIGNED: 19 Feb 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Removal
DATE THEREOF: 20 Feb 53
NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetary
LOCATION (City, town, or county) (State): Wilmington, Delaware

DATE REC'D BY LOCAL REG. 19 Feb 53
REGISTRAR'S SIGNATURE: ARTHUR J. COMBOSH Capt. MSC
24. FUNERAL DIRECTOR ADDRESS: JOANNA-CORLETTO FUNERAL HOME WILMINGTON, DEL

2VV24404

FEB
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 81200 H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen'l

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE md COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) R (Last) CYR JR.

4. DATE OF DEATH: (Month) 2 (Day) 8 (Year) 53 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S

8. DATE OF BIRTH: Feb. 6, 53

9. AGE last birthday: — yrs. IF UNDER 1 YEAR: Months — Days 2 IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James R. Cyr Sr.

14. MOTHER'S MAIDEN NAME: Lucille C Milburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: James R. Cyr Sr. Severna Park, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) Cyanotic Congenital Heart Disease — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) interventricular septal defect — DUE TO

(c)

7543

INTERVAL BETWEEN ONSET AND DEATH: Since Birth

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Feb, 1953, to 7 Feb, 1953, that I last saw the deceased alive on 7 Feb, 1953, and that death occurred at 5 PM m., from the causes and on the date stated above.

SIGNATURE Philip Brucia — (DEGREE OR TITLE) MD — ADDRESS 212 Prince George St — DATE SIGNED 2/7/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 2/10/53 — NAME OF CEMETERY OR CREMATORY St Mary's Cemetery — LOCATION (City, town, or county) Annapolis, Md — (State)

DATE REC'D BY LOCAL REG. Feb. 9, 1953 — REGISTRAR'S SIGNATURE [signature] — **24. FUNERAL DIRECTOR** B. L. Tipping & Son — ADDRESS Annapolis, Md.

223212405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01201

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 179 Main

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) E. (Last) Davis
4. DATE OF DEATH: (Month) 2 (Day) 21 (Year) 1953
5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (write): Single
8. DATE OF BIRTH: 4/3/1871
9. AGE last birthday: 81 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Home work
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Samuel Davis
14. MOTHER'S MAIDEN NAME: Elizabeth V. Sydings
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Arthur J. Elliott Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

Immediate cause (a) Arteriosclerotic Heart disease — 3 years.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Bronchitis — Several years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Feb 21, 1953, that I last saw the deceased alive on Feb 21, 1953, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
Grace C Bozic | M D | Annapolis Md | 2-23-53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2/23/53 | NAME OF CEMETERY OR CREMATORY St. Anne's | LOCATION (City, town, or County) Annapolis | (State) Md.

DATE REC'D BY LOCAL REG. Feb 23, 1953 | REGISTRAR'S SIGNATURE [illegible] D.H. | 24. FUNERAL DIRECTOR John M. Tyler & Son | ADDRESS Annapolis Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01202

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS General Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Annapolis
STREET ADDRESS (If rural, give location) General Highway

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Housley (Last) Dawson

4. DATE OF DEATH: (Month) February (Day) 1 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: June 15, 1912

9. AGE last birthday: 40 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: George A. Dawson

14. MOTHER'S MAIDEN NAME: Mary Housley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Mary W. Dawson Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Ischemia	6 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Constrictive Pericarditis	yrs.
	(c) Rheumatic Heart Disease	20 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/6/1952 to 1/31/1953 that I last saw the deceased alive on 1/31/1953 and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M. Shirley M.D. Annapolis 2/6/53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 2-5-1953 NAME OF CEMETERY OR CREMATORY Edwards Chapel LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Feb 2, 1953

REGISTRAR'S SIGNATURE M. D. Powell Jr. Deputy

24. FUNERAL DIRECTOR John H. Taylor & Son ADDRESS Annapolis, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1P 203 4

MARGIN RESERVED FOR BINDING

(PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information refully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Glen Haven (Pasadena P.O.)

LENGTH OF STAY (in this place) Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS 6th Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Haven (Pasadena P.O.)

STREET ADDRESS (If rural, give location) 6th Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Paulette	Faye	Disney	Feb	27,	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Single	June 17, 1952	— yrs.	8			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
None	None	Annapolis, Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Ray Disney	Beatrice Costello

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	—	None	Ray Disney, Glen Haven (Pasadena P.O.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute bronchopneumonia	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Mongolism since birth

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from July 15 1952 to Feb. 27 1953, that I last saw the deceased alive on Feb. 27, 1953 and that death occurred at 4:15 p.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
R. M. McLaughlin	M.D.	Pasadena, Md.	Feb. 27, 1953

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/2/53	Glen Haven	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/2	[signature]	R V Singleton	Glen Burnie, Md.

206239640 5

Film G154, Item 2 6/10/53 mnb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01204 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
   COUNTY: Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL) OR TOWN: Crownsville
   LENGTH OF STAY (in this place): 2yrs.11mo.
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland — COUNTY: Charles
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: unknown
   STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) O. (Last) Dorsey

4. DATE OF DEATH: (Month) Feb. (Day) 23 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: unknown

9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Mm.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
   (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: ----

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Pulmonary tuberculosis — unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. senility

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: --

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) --

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY --

(CITY OR TOWN) ---

(COUNTY)

(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) -- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from 2/1, 19 53 to 2/23, 19 53, that I last saw the deceased alive on 2/22, 19 53, and that death occurred at 7:30AM, from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold H. Eichert M.D.

ADDRESS: Crownsville, Maryland

DATE SIGNED: 2/23/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2/27/53

NAME OF CEMETERY OR CREMATORY: Sand Heat

LOCATION (City, town, or county) (State): La Plata, Md

DATE REC'D BY LOCAL REGISTRAR: 2-25-53

REGISTRAR'S SIGNATURE: M. L. Mourse

24. FUNERAL DIRECTOR: Hewitt & Byron

ADDRESS: Waldorf, Md

K. M. Joyce-emc

VS A15

COPY

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

F 205

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY A. A. Co; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mitchelsville (Rural) Annapolis; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) Sadonia (Last) Evans

4. DATE OF DEATH: (Month) Feb. (Day) 16 (Year) 1953

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Jan. 13, 1924

9. AGE last birthday: 29 yrs. If under 1 year: Months; Days 3. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautician

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md. A. A. Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Owens

14. MOTHER'S MAIDEN NAME: Henretta Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Henretta Owens. Mitchelsville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia — Interval between onset and death: 3 wks

4934 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE O. Smithpeter (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 2/16/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Feb. 20, 1953 | NAME OF CEMETERY OR CREMATORY Galilee | LOCATION (City, town, or county) Harwood (State) Md.

DATE REC'D BY LOCAL REG. Feb 20, 1953 | REGISTRAR'S SIGNATURE Carrie Jointt 2-23- | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis, Md.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

61206

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena — LENGTH OF STAY (in this place) 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 487 A Ritchie Hewy.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Fawthrop

4. DATE OF DEATH (Month) (Day) (Year): Feb. 23-1953 19

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 12/7/67

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired house wife.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New York State.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Johnson

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Irene Eberlein (grand daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4 1.1 Immediate cause (a) Coronary Occlusion — 4 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ,, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ,, homicide ,, undetermined ☐.*

SIGNATURE: Gustave A Rauhendorf. (Degree or title): Deputy Medical Examiner, ADDRESS: Glen Burnie, Md. DATE SIGNED: 2/23/53

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE THEREOF: 2/26/53 — NAME OF CEMETERY OR CREMATORY: Clifton Park — LOCATION (City, town, or county) (State): N.Y.

DATE REC'D BY LOCAL REG. 3-6-53 — REGISTRAR'S SIGNATURE: L. J. De Alba

24. FUNERAL DIRECTOR: Marshall Hon. — ADDRESS

CMC

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

COPY SENT TO [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01207

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 35 Jefferson Place

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) Aloysius (Last) Frank
4. DATE OF DEATH (Month) 2 (Day) 17 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married
8. DATE OF BIRTH: Nov 15 1880
9. AGE last birthday: 72 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Watchman U.S. Naval Academy
10b. KIND OF BUSINESS OR INDUSTRY: Watchman
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Peter A. Frank
14. MOTHER'S MAIDEN NAME: Bridget Kelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish American
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Myra H Frank Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage with — Interval Between Onset and Death: 2-6-53

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) left hemiplegia — Same
(c) Arteriosclerosis — Same

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — Same

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

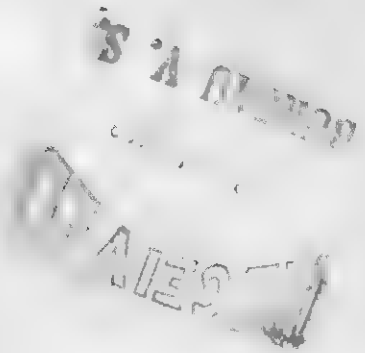
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-6, 1953, to 2-17, 1953, that I last saw the deceased alive on 2-17, 1953, and that death occurred at 11.05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
George C. Basil M.D. Annapolis Md 2-19-53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2-20-53 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Feb 20, 1953 | REGISTRAR'S SIGNATURE J. Edward Howard (S.W.) | 24. FUNERAL DIRECTOR John W. Layton Sons ADDRESS Annapolis Md



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2-7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Laurel
LENGTH OF STAY (in this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Meade Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Laurel
STREET ADDRESS (If rural, give location) Fort Meade Road

3. NAME OF DECEASED: (Type or Print) (First) Rosa (Middle) Jane (Last) Franklin

4. DATE OF DEATH: (Month) (Day) (Year) February 16 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: March 25 1889

9. AGE last birthday: 63 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant

10b. KIND OF BUSINESS OR INDUSTRY: District Farming School

11. BIRTHPLACE (State or foreign country): Appomattox Co. Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Yodara Jane

14. MOTHER'S MAIDEN NAME: Isabelle Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 225-03-6322

17. INFORMANT & ADDRESS: M. M. Nash, Laurel, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

426.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 15 Mins.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Myocarditis — 2 yrs

DUE TO

(c) Obesity. — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/17, 19 49, to 4/10, 19 53, that I last saw the deceased alive on 2/8, 19 53, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) M.D. ADDRESS Laurel DATE SIGNED 2/17/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 2/19/53

NAME OF CEMETERY OR CREMATORY Liberty Baptist Cem.

LOCATION (City, town, or county) (State) Appomattox Virginia

DATE REC'D BY LOCAL REG. 2-17-53

REGISTRAR'S SIGNATURE Clara Todd

24. FUNERAL DIRECTOR Whitten Funeral Home

ADDRESS Lynchburg, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (2019)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis (Rural) Route
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Alice (Last) Gray

4. DATE OF DEATH: (Month) Feb. (Day) 19 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Sept. 12, 1908

9. AGE last birthday: 44 yrs. IF UNDER 1 YEAR: Months 5 Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired). School teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lewisburg Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles C. Foreman

14. MOTHER'S MAIDEN NAME: Ada Nash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
416X Immediate cause	(a) Auricular Fibrillation	2 wks.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Rheumatic Heart Disease	4 Mos.
	(c) DUE TO	

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/14, 1953, to 2/19/, 1953, that I last saw the deceased alive on 2/18/, 1953, and that death occurred at 4 50 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank M Shipley M.D. Annapolis 2/21/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF Feb. 28 1953 NAME OF CEMETERY OR CREMATORY Family LOCATION (City, town, or county) (State) Lewisburg, Pa.

DATE REC'D BY LOCAL REGISTRAR Feb 21, 1953 REGISTRAR'S SIGNATURE F W. 24. FUNERAL DIRECTOR ADDRESS J.B. Johnson, Annapolis, Md.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 North West St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 60 North West St.

3. NAME OF DECEASED (Type or Print): (First) Henry; (Middle) ; (Last) Green

4. DATE OF DEATH: (Month) 2; (Day) 8; (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: June 6, 1901

9. AGE last birthday: 52 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Acad.

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jasper Green

14. MOTHER'S MAIDEN NAME: Millie Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No; (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: Sarah Green - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Base of Tongue & Left Groin

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1953, to Feb. 8, 1953, that I last saw the deceased alive on Feb. 8, 1953, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE: K. W. Richardson (Degree or title) M.D. ADDRESS: Annapolis, Md. DATE SIGNED: 2-11-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2-12-53

NAME OF CEMETERY OR CREMATORY: Brewer Hill

LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: William Reese

ADDRESS: 4-10 E. Washington St. Annapolis, Md.

Item 18 Film G151 2-13-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01211

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY a.a. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum | LENGTH OF STAY (in this place) 28 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 So. Hammonds Ferry Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY a.a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location) 104 S. Hammonds Ferry Road.

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) Karl (Last) Grempler.
4. DATE OF DEATH: (Month) Feb. (Day) 9 (Year) 1953

5. SEX: M. | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: April 13 '93 | 9. AGE last birthday: 59 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Laundry Supplies
11. BIRTHPLACE (State or foreign country): Baltimore Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Karl Grempler
14. MOTHER'S MAIDEN NAME: Ellen Lyons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of): No
16. SOCIAL SECURITY No.: 162-03-5221
17. INFORMANT: Mrs. Rose Grempler - Linthicum Hgts.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Abdominal Aortic Aneurism Ruptured	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (Hardening of) Aneurism	1 yr.
	(c)	

45 IX

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1952 to Feb. 9, 1953, that I last saw the deceased alive on Feb. 9, 1953, and that death occurred at 12:50 A.m., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr. (Degree or title) | ADDRESS: Linthicum | DATE SIGNED: Feb. 9 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Feb-11-1953 | NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery | LOCATION (City, town, or county) (State): Baltimore, Maryland.

DATE REC'D BY LOCAL REG. 2-13-53 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR: Stewart & Mowen Co. | ADDRESS: 108 W. North Ave. City #1.

VS. A15

NON-SYPHILITIC 2/13/53 Dr. Ball.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11212

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Kent
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golts
STREET ADDRESS (If rural give location): R. F. D. #1

3. NAME OF DECEASED: (Type or Print) (First) Nora (Middle) (Last) Hall

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1868?

9. AGE Last birthday: 85? yrs. IF UNDER 1 YEAR: Months 2 Days – IF UNDER 24 HRS: Hours – Min. –

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Louis Ringle

14. MOTHER'S MAIDEN NAME: Laura Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) – – –

16. SOCIAL SECURITY NO.: – – – –

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

43 ?

Immediate cause (a) Arteriosclerotic and degenerative heart disease — Interval Between Onset And Death: 10 yrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: – – – – 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) – – – – – PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) – – – – – (CITY OR TOWN) – – – – – (COUNTY) – – – – – (STATE) – – – – –

TIME OF INJURY (Month) (Day) (Year) (Hour) – – – – – – – – m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR? – – – – – – – – – – – –

22. I hereby certify that I attended the deceased from 2/1 ,19 53 to 2/4 , 19 53, that I last saw the deceased alive on 2/4 , 19 53, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D. ADDRESS Crownsville, Md. DATE SIGNED 2/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2/11/53 | NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. | LOCATION (City, town, or county) (State) Crownsville, Md.

DATE REC'D BY LOCAL REGISTRAR 2-10-53 | REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Arnold H. Eichert, M.D. ADDRESS Crownsville, Md.

VS/A15

RECEIVED
FEB 13 1953
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

61213

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A-16

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 44 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 93 Washington Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 93 Washington Street

3. NAME OF DECEASED (Type or Print): (First) Matilda (Middle) Mary (Last) Harris

4. DATE OF DEATH (Month) (Day) (Year): 2/24/1953 19

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 10/2/1893

9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundress-U.S. Naval A.

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Bristol, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Brown

14. MOTHER'S MAIDEN NAME: Mary Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mary Hamilton-93 Washington St. Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

42 a/

Immediate cause (a) Coronary Thrombosis — 4 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis. Cardiac Vascular Disease — 8 yrs +

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/2, 1938, to 2/24, 1953, that I last saw the deceased alive on 2/19, 1953, and that death occurred at 1:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice Klevans MD — ADDRESS Annapolis, Md — DATE SIGNED 2/26/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 2/27/1953 — NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery — LOCATION (City, town, or county) (State): West St. Annapolis, Md.

DATE REC'D BY LOCAL REG.: Feb 27, 1953 — REGISTRAR'S SIGNATURE: [illegible] Asst.

24. FUNERAL DIRECTOR — ADDRESS: Ethel L. Hicks-45 Northwest. St. Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01214 28

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH:
COUNTY Ann. Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 yr.4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge
STREET ADDRESS (If rural give location) Maces Lane

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Jews

4. DATE OF DEATH: (Month) 2 (Day) 27 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 1881?

9. AGE last birthday: 72? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Handy Man

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Hooden Jews

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY No.: — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 X

Immediate cause (a) Pulmonary Tuberculosis — Interval Between Onset And Death: Unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —

19b. MAJOR FINDINGS OF OPERATION. —

20. AUTOPSY ? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1 ..., 1953, to 2/27 ..., 1953., that I last saw the deceased alive on 2/27 ., 1953 and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold A. Eichert M.D

ADDRESS Crownsville, Md.

DATE SIGNED 2/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 3/13/53

NAME OF CEMETERY OR CREMATORY University Med School Baltimore

LOCATION (City, town, or county) Md (State)

DATE REC'D BY LOCAL REGISTRAR 3/13/53

REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR Frances A Hemsley

ADDRESS 578 N Biddle St

J. M. Joyce - cmc

Item 9 FilmG153 4/29/53 mhw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 32330

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Monument St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 14 Monument St.

3. NAME OF DECEASED: (First) Henry (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) 2 (Day) 27 (Year) 1953

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 12-26-1893 | 9. AGE, last birthday: 60 59 yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Domestic | 10b. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): A.A. Co. Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Johnson | 14. MOTHER'S MAIDEN NAME: Louise Casey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: None | 17. INFORMANT & ADDRESS: Eleanor Johnson - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2

Immediate cause (a) Myocardial Failure DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 10 month

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1953 to Feb 27, 1953, that I last saw the deceased alive on Feb 27, 1953, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE R. E. Edwards (Degree or title) M.D. ADDRESS 110 Clay St Annapolis DATE SIGNED 3/1/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 3-4-1953 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR March 4, 1953 | REGISTRAR'S SIGNATURE J. D. Bowen B.W. | 24. FUNERAL DIRECTOR William Reese & Son ADDRESS 108 N. Washington St. Annapolis, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

9215

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Lincoln Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lincoln
LENGTH OF STAY (In this place) 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mrs. Stanka Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Kentucky COUNTY Fayette
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morgantown
STREET ADDRESS (If rural, give location) Route #7

3. NAME OF DECEASED (Type or Print): (First) Isaac (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) February (Day) 21 (Year) 1953

5. SEX: Male | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced | 8. DATE OF BIRTH: 11/2/72 | 9. AGE last birthday: 80 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer retired
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Morgantown, Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Columbus P. Johnson
14. MOTHER'S MAIDEN NAME: Mary E. ~~Johnson~~ Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 406-28-8650
17. INFORMANT AND ADDRESS: W. Owen Johnson Lincoln

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
40 min. Immediate cause	(a) Coronary Occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): —
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? —

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Lancaster A. Parker M.D. (Degree or title) M.D. ADDRESS: Glen Rose, Ky. DATE SIGNED: 2/21/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 2-24-53 | NAME OF CEMETERY OR CREMATORY: Hillcrest | LOCATION (City, town or county): Morgantown (State): Ky

DATE REC'D BY LOCAL REG. 2/22/53 | REGISTRAR'S SIGNATURE: J. DeAlba | 24. FUNERAL DIRECTOR: Leonard A. Finch | ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

CERTIFICATE OF DEATH

Reg. Dist. No. 1216 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
LENGTH OF STAY (in this place): 2½ mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
STREET ADDRESS (If rural give location): 2313 Arunah Ave. ✓

3. NAME OF DECEASED (Type or Print): (First) Cordelia (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 2 (Day) 3 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1885?

9. AGE last birthday: 68? yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk. (If Yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: — — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

4221
Immediate cause (a) Hypostatic Pneumonia — 2 days
DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last.
(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Cardiovascular Disease

19a. DATE OF OPERATION: — — — — —

19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1, 19 53, to 2/3, 19 53, that I last saw the deceased alive on 2/3, 19 53, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold H. Eichert M.D.
ADDRESS: Crownsville Md.
DATE SIGNED: 2/3/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 2/7/53
NAME OF CEMETERY OR CREMATORY: Mt Auburn
LOCATION (City, town, or county) (State): Baltimore Md

DATE REC'D BY LOCAL REGISTRAR: Feb 5/1953
REGISTRAR'S SIGNATURE: L. J. De Alba

24. FUNERAL DIRECTOR: Frances A Hemsley
ADDRESS: 578 W Biddle St

2/6/53 K. M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; HOSPITAL OR INSTITUTION OR STREET ADDRESS 89 Shipwright St.; LENGTH OF STAY (in this place) MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY aa; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 89 Shipwright St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) James (Last) Kane

4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Single

8. DATE OF BIRTH: 1/1/1902

9. AGE last birthday: 51 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Storekeeper U.S.N.A. Public Works Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Naval Academy

11. BIRTHPLACE (State or foreign country): Newark N.J.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Patrick J. Kane

14. MOTHER'S MAIDEN NAME: Annie E. Leddy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs Rose K. Linder Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42 hrs.

Immediate cause (a) Acute Coronary Thrombosis — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cr. Gastric Ulcer — Several yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 8, 1953, to Feb 11, 1953, that I last saw the deceased alive on Feb. 9, 1953, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Oliver Purvis M.D. 40 Franklin Sq. St. Annapolis Md 2/12/53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 2-16-53 NAME OF CEMETERY OR CREMATORY Naval Academy LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Feb. 16, 1953 REGISTRAR'S SIGNATURE H. C. Linder

24. FUNERAL DIRECTOR John W. Taylor Sons ADDRESS Annapolis Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1059

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Glen Burnie; LENGTH OF STAY (In this place) 2 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 205 Cedar Drive Marley Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same; STREET ADDRESS Same (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Bernard (Middle) (Last) Kappold

4. DATE OF DEATH (Month) Feb. (Day) 19- (Year) 1953

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9/23/69

9. AGE last birthday: 83 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired shoemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany, Europe.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Kappold

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Janie Kappold (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9/6 X

Immediate cause (a) Cerebral hemorrhage due to self inflicted

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) wound, caused by a bullet, caliber 22

(c) from a Remington rifle. — Interval Between Onset and Death: Sudden

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN) (COUNTY) (STATE): Marley Park, Glen Burnie, A.A. Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 2/19/53 8.45 A.M. INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? By shooting a bullet through his (head.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐.*

SIGNATURE Gustave A. Paulert M.D. (Degree or title) Deputy Medical Examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 2/19/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE THEREOF: 2/23/53; NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery; LOCATION (City, town, or county) (State): Glen Burnie, AA. Md

DATE REC'D BY LOCAL REG. 2/23/53; REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR: R. V. Singleton ADDRESS

VS. A-5A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

6 217

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover; LENGTH OF STAY (In this place) 2 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible] Ridge Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; STREET ADDRESS (If rural, give location) [illegible]

3. NAME OF DECEASED (Type or Print): (First) Jacob (Middle) [illegible] (Last) KAZLA.

4. DATE OF DEATH: (Month) February (Day) 10 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.

8. DATE OF BIRTH: 3/23/72

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired.

11. BIRTHPLACE (State or foreign country): CZECHOSLAVAKIA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT AND ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.:

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterial Sclerosis — 7

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [illegible] (Degree or title) [illegible] ADDRESS [illegible] DATE SIGNED 2/10/53

23. BURIAL, CREMATION, REMOVAL (Specify) D. — DATE THEREOF 2.16.53 — NAME OF CEMETERY OR CREMATORY Cedar Hill. — LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REG. 2/16/53 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR [illegible] ADDRESS 130 G. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01220

Reg. Dist. No. 27

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (in this place) 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania — COUNTY Clearfield
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Philipsburg
STREET ADDRESS (If rural give location) RFD Box 305

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) Lee (Last) Kerfoot

4. DATE OF DEATH: (Month) February (Day) 22 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant

8. DATE OF BIRTH: 21 February 53

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Paul Kerfoot

14. MOTHER'S MAIDEN NAME: Florence Akina

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: 2000 ASU, Ft George G Meade, Md. (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

76 2.0

Immediate cause (a) Neonatal Atelectasis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) .....

DUE TO

(c)

Interval Between Onset And Death: 1 day

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 22 Feb, 1953, to 22 Feb, 1953, that I last saw the deceased alive on 22 Feb, 1953, and that death occurred at 1750 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Merrill F. Nelson, Capt MC

ADDRESS Merrill F. NELSON Capt MC (MD) Fort George G Meade, Md

DATE SIGNED 22 February 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 24 Feb 53

NAME OF CEMETERY OR CREMATORY Post Cemetary

LOCATION (City, town, or county) (State) Fort George G Meade, Md

DATE REC'D BY LOCAL REGISTRAR 24 Feb 53

REGISTRAR'S SIGNATURE Arthur J. Gordon

24. FUNERAL DIRECTOR J.P. SPENCER Chaplain

ADDRESS Ft Geo G Meade, Md.

2023314393

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1221

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): Richie and Park St.

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) LOUISE (Last) KIRBY

4. DATE OF DEATH: (Month) FEBRUARY (Day) 19, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 30, 1922

9. AGE last birthday: 30 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas B. BREWER

14. MOTHER'S MAIDEN NAME: Isabelle HAWKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.: 213-14-0200

17. INFORMANT & ADDRESS: Mr. Norman L. Kirby Husband same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

684.7

Immediate cause (a) Pulmonary Embolism — DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) — DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Pregnancy (32 wks)

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 A M to 1.45 P M Feb 19-53, 19..., to ..., 19..., that I last saw the deceased alive on Feb 19, 19 53 and that death occurred at 1.45 P.M., from the causes and on the date stated above.

SIGNATURE: George C. Bacil — (DEGREE OR TITLE) M.D. — ADDRESS: Annapolis md — DATE SIGNED: 2-20-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2-22-53

NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Feb 24 1953

REGISTRAR'S SIGNATURE: [signature] Reg.

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

0222

Reg. Dist. No. . . . . .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

1. PLACE OF DEATH: COUNTY A.A.Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne-Arundel Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Klefeker (Last)

4. DATE OF DEATH: (Month) (Day) (Year) 2/6/53 19

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.

8. DATE OF BIRTH: Oct 11 1911

9. AGE last birthday: 41 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Paper supplies

11. BIRTHPLACE (State or foreign country): Newark, New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles B. Klefeker

14. MOTHER'S MAIDEN NAME: Anna F. Dowling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Charles F. Klefeker PO 69 Newark N.Y

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause — (a) Acute pulmonary congestion & edema due to 24 hrs.
injury to left upper chest.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Left hemopneumothorax (1,2,3,4,5 & 8 on left) due to 4 days
multiple fractures 7 ribs

(c) Severe compression injury left chest. - (over)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2-6-52

19b. MAJOR FINDINGS OF OPERATION: Hemopneumothorax -

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Highway — (CITY OR TOWN) — (COUNTY) A.A.Co — (STATE) MD.

TIME OF INJURY (Month) (Day) (Year) (Hour): 2 2 52 P m. — INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Auto accident

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Elmer Fuchs — (Degree or title) M.D. — ADDRESS Annapolis Md — DATE SIGNED 2/9/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 2/10/53 — NAME OF CEMETERY OR CREMATORY: Newark Cemetery — LOCATION (City, town, or county) (State): Newark New York

DATE REC'D BY LOCAL REG. 2-7-53 — REGISTRAR'S SIGNATURE: LL

24. FUNERAL DIRECTOR: CHARLES F. EVANS & SON — ADDRESS: 118 W. Mt. Royal Ave.

also had:

Disarticulation of left sterno-clavicular joint.

Extravasation of blood into tissues of neck, chest wall & mediastinum.

Vascular congestion of meningeal blood vessels with capillary oozing into subarachnoid space.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

81223

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nutwell
LENGTH OF STAY (In this place) 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nutwell
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) John Franklin (Last) Leitch

4. DATE OF DEATH: (Month) Feb (Day) 27 (Year) 1953

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: May 31 1880 | 9. AGE Last birthday: 72 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming (Day work) | 10b. KIND OF BUSINESS OR INDUSTRY: Tobacco farmer | 11. BIRTHPLACE (State or foreign country): Friendship Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Leitch | 14. MOTHER'S MAIDEN NAME: Anna E. Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO.: no | 17. INFORMANT AND ADDRESS: Ralph Leitch Nutwell Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Bowie Linn Grant | (Degree or title) M.D. | ADDRESS: Shady Side, Md. | DATE SIGNED: Mar. 1st 53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: March 1 1953 | NAME OF CEMETERY OR CREMATORY: Friendship | LOCATION (City, town, or county) (State): Friendship Md

DATE REC'D BY LOCAL REG.: Mar. 1. 53 | REGISTRAR'S SIGNATURE: J. B. Dent

24. FUNERAL DIRECTOR: Hardesty Funeral Home Galesville Md | ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2221

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. G. General Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Weems Creek
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Clara (Middle) E. (Last) Loftus

4. DATE OF DEATH: (Month) 2 (Day) 16 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jany 2 1862

9. AGE last birthday: about 91 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None wife

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William H. Parsons

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: George P. Loftus Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset and Death: 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension C.V.D. — 3 Yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19.5.1., to ....., 19....., that I last saw the deceased alive on 2/16/, 1953, and that death occurred at 10.22 p.m., from the causes and on the date stated above.

SIGNATURE: Frank M. Lupfer (Degree or title) MD ADDRESS: Annapolis DATE SIGNED: 2/18/53

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) — DATE THEREOF 2-19-53 — NAME OF CEMETERY OR CREMATORY St Mary's — LOCATION (City, town, or county) Baltimore — (State) Md

DATE REC'D BY LOCAL REG. Feb. 19, 1953 — REGISTRAR'S SIGNATURE H. C. Brown D.C. — 24. FUNERAL DIRECTOR John M. Layle & Son — ADDRESS Annapolis Md

VS A-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01225

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn Beach
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn Beach
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Emma	Mary	Lokey	2 - 24 - 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W.	Widow	May 20-1872	80 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Home	Princess Ann Md.	U.S.A.

13. FATHER'S NAME
Isaac Mathews

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS
Mrs Michael H. Conner Woodlawn Beach

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Senility	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

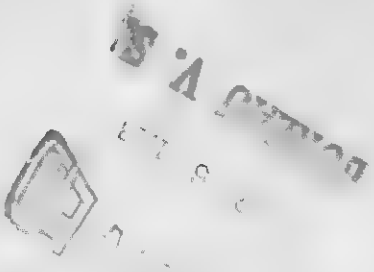
22. I hereby certify that I attended the deceased from 20 Feb, 1953, to 23 Feb, 1953, that I last saw the deceased alive on 23 Feb, 1953, and that death occurred at 12 M m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward Kelt	M D	41 Southgate Ave Annapolis	24 Feb 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	2-26-53	Hillcrest Memorial	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
Feb 26, 1953	Edward Culleson	John M. Eagle Sons	Annapolis Md.

VS. A15



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01226

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 60 Clay Street

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Robert (Last) Love
4. DATE OF DEATH (Month) [illegible] (Day) 23 (Year) 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 10/14/1[illegible]
9. AGE last birthday 43 yrs.
If under 1 year Months / Days
If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Painter
11. BIRTHPLACE (State or foreign country) [illegible] Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME [illegible] Sr.
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS [illegible] Ho. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
1(a) Immediate cause	(a) Broncho-pneumonia	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis	?
	(c) Bronchogenic Carcinoma	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/11/52, 19[illegible] to 2/8/53, 19[illegible], that I last saw the deceased alive on 2/7/53, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank McKinley, M.D. Annapolis 2/10/53

23. BURIAL, CREMATION / REMOVAL (Specify)
DATE THEREOF
NAME OF CEMETERY OR CREMATORY [illegible] Memorial Cemetery
LOCATION (City, town, or county) (State) West St., Annapolis, Md.

DATE REC'D BY LOCAL REG. Feb. 11, 1953
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR ADDRESS
Ethel L. Hicks-45 Northwest St.
Annapolis, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 5227

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the uses of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn — LENGTH OF STAY (In this place): 27 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4803 - Ritchie Highway

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arnold
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Albert (Last) Isaac.

4. DATE OF DEATH: (Month) 2 - (Day) 6 - (Year) 1953

5. SEX: Male. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 12/14/87 | 9. AGE last birthday: 65 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Freight Inspector. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Isaac | 14. MOTHER'S MAIDEN NAME: Catherine Ingram.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No | 16. SOCIAL SECURITY NO.: 212-18-6118 | 17. INFORMANT AND ADDRESS: Mrs. R. Isaac (wife.)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Gustave A. Reubert M.D. Medical Examiner. Glen Burnie, Md. 2/9/53

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL | DATE THEREOF: Feb 10, 1953 | NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL | LOCATION (City, town, or county) (State): BALTIMORE, MD.

DATE REC'D BY LOCAL REG.: 2/9/53 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS: GEORGE I. GONCE 4001 RITCHIE Hwy.

Dorf

VS-A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

229

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY P.A.CO. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) Dau
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen'l.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural, give location) Benfield Rd - Box 519-B Route #2

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRANK.	G. C.	MARTIN	2	6	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M.	W.	MARRIED	March 6 1880	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Private Chauffeur (ret.)	Dunlop family	England	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Martin	Christina Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Minnie K. Martin - Severna Park

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary disease	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home	(CITY OR TOWN)	(COUNTY)	(STATE)
			P.A.CO	MD.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☑	HOW DID INJURY OCCUR?
2 - 6 '53 P m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	MD	Annapolis Md	2/6/53.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	2/10/53	Loudon Park	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/9/53	[signature]	R V Singleton	Glen Burnie, Md.

VS. A15A

1055

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 20

11220

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~~Patuxent~~ Central Ave.
MARYLAND LENGTH OF STAY (in this place): 4yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
STREET ADDRESS (If rural give location): Central Ave.

3. NAME OF DECEASED: (Type or Print) (First) Tabitha (Middle) C. (Last) McGinnis

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 14, 1893

9. AGE Last birthday: 59 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joe Tucker

14. MOTHER'S MAIDEN NAME: Ellen ~~Cashman~~ Haines

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Doris Neall - Davidsonville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

Immediate cause (a) Cerebral thrombosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis - hypertension
DUE TO (c) generalized arteriosclerosis -

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 19 [illegible], to Feb. 16, 1953, that I last saw the deceased alive on Feb. 16, 1953, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Emily H. Wilson, M.D.
ADDRESS: Cattleen, Md.
DATE SIGNED: 2-16-53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Feb. 18, 1953
NAME OF CEMETERY OR CREMATORY: Cedar Hill
LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECD BY LOCAL REGISTRAR: 2/18
REGISTRAR'S SIGNATURE: L. L. De Alba

24. FUNERAL DIRECTOR ADDRESS: W. Singleton, Glen Burnie, Md.

Edward Collemon - care

VS/A15

FEB

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
LENGTH OF STAY (in this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) B (Last) McKee
4. DATE OF DEATH: (Month) Feb. (Day) 14, (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 30, 1898
9. AGE last birthday: 54 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Examiner
10b. KIND OF BUSINESS OR INDUSTRY: Govt
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John McKee
14. MOTHER'S MAIDEN NAME: Fortunia Brummett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Marion M. Kee — 1570 Chillum Rd. Hyattsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 15 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertensive C.V.D. — 2+ yrs.
(c) Diabetes Mellitus — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Left oculomotor nerve paralysis — 2 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour):
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/12/51, to 10/7/52, that I last saw the deceased alive on 10/7/52, and that death occurred at 5:40 A.m., from the causes and on the date stated above.

SIGNATURE: Frank M. Shipley (Degree or title) M.D. ADDRESS: Annapolis DATE SIGNED: 2/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 2-17-53
NAME OF CEMETERY OR CREMATORY: Congressional Cem.
LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REG.: 2-14-53
REGISTRAR'S SIGNATURE: Amanda Brandy
24. FUNERAL DIRECTOR: J. W. McKee's Sons — ADDRESS: 300-4-2 St. N.E. Washington, D. C.

2-19-53 Trench-cmc

DATE
FEB 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. 115

1. PLACE OF DEATH:
   COUNTY: Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
   LENGTH OF STAY (in this place): 6½ mos.
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland — COUNTY: Baltimore City
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
   STREET ADDRESS (If rural give location): 234 Beale Court ✓

3. NAME OF DECEASED: (First) Lillian (Middle) (Last) Miester
4. DATE OF DEATH: (Month) 2 (Day) 1 (Year) 19 53
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1/20/86
9. AGE last birthday: 67 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Edward Hill
14. MOTHER'S MAIDEN NAME: Adella Storer Hill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk. (If Yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
44.2 K Immediate cause	(a) Chronic Myocarditis	Known to us
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular Disease	since ad. 8/14/52
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: - - - - -
19b. MAJOR FINDINGS OF OPERATION: - - - - -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): - - - - -
(CITY OR TOWN) (COUNTY) (STATE): - - - - -
TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? - - - - -

22. I hereby certify that I attended the deceased from 8/14/52, to 2/1/, 19 53, that I last saw the deceased alive on 2/1, 19 53 and that death occurred at 2:00 am, from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 2/1/53

23. BURIAL, CREMATION, REMOVAL (Specify): XXXXXXXX
DATE THEREOF: 2/3/53
NAME OF CEMETERY OR CREMATORY: Mt. Calvary
LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR: 2/4/53
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: Edwin O. Wilson
ADDRESS: 1005 Brantley Ave

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02346

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS, A15A

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS RT 2 Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Mass; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharon; STREET ADDRESS (If rural, give location) 15 Edgewood Rd

3. NAME OF DECEASED (Type or Print): (First) BEATRICE (Middle) H (Last) MORGAN

4. DATE OF DEATH (Month) FEBRUARY (Day) 2 (Year) 53 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	June 3, 1900	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Cleveland Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: James H. Morgan Annapolis, Md. Rfd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

330X **Immediate cause** (a) Subarachnoid hemorrhage — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ; (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. INJURY None

PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) St. Margarets (COUNTY) Anne Arundel (STATE) Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour) 2-2-53 12:15 p.m.; INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Natural causes

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED

Elmer G. Linhardt M.D. Medical Examiner Anne Arundel County, Annapolis, Md. 2-5-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-5-53	Fort Lincoln Cemetery	Washington, D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1953	[signature] Bw.	[illegible]	[illegible]

Item 3 FilmG151 2/20/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27 (1232)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): FortGeorge G Meade
LENGTH OF STAY (in this place): 16 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Florida — COUNTY: Volusia
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DeLand
STREET ADDRESS (If rural give location): -

3. NAME OF DECEASED: (Type or Print) (First) Warrene (Middle) Ray (Last) Murphy

4. DATE OF DEATH: (Month) February (Day) 12 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 19 Feb 1880

9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Ray

14. MOTHER'S MAIDEN NAME: Anne Ethel Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -

17. INFORMANT & ADDRESS: Col. Frank Harris, Fort George G Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42 ??

Immediate cause (a) Acute Congestive Heart Failure

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

Interval Between Onset And Death

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. -

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -

(CITY OR TOWN) (COUNTY) (STATE) -

TIME OF INJURY (Month) (Day) (Year) (Hour) m. -

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 12 Feb, 19 53, to 12 Feb, 1953, that I last saw the deceased alive on 12 Feb., 19 53, and that death occurred at 1920, from the causes and on the date stated above.

SIGNATURE: J.J. Goodman — (Degree or title) J.J. GOODMAN 1st Lt MC (MD) — ADDRESS: Fort George G Meade, Md. — DATE SIGNED: 12 Feb 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Removal

DATE THEREOF: 14 Feb 53

NAME OF CEMETERY OR CREMATORY: DeLand Cemetary

LOCATION (City, town, or county) (State): DeLand, Florida

DATE RECD BY LOCAL REGISTRAR: 12 Feb 1953

REGISTRAR'S SIGNATURE: Arthur J Gombosh

FUNERAL DIRECTOR: ARTHUR J GOMBOSH Capt MSC — Allen-Summerhill — ADDRESS: Deland, Florida

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01233

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups | LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Balto -
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Balto
STREET ADDRESS (If rural, give location): 3633 Pulaski Hwy.

3. NAME OF DECEASED (Type or Print): (First) Howard (Middle) Ernest (Last) NINER.

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1953

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: Nov. 12, 1909 | 9. AGE last birthday: 43 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic | 10b. KIND OF BUSINESS OR INDUSTRY: Auto. | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Ed. Niner

14. MOTHER'S MAIDEN NAME: Frances E. Rockwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none | (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215 - 01 - 4900

17. INFORMANT AND ADDRESS: M.H.C. records & Brother.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

551.0 Immediate cause (a) Coma -

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CIRRHOSIS OF LIVER.

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2½ Mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1952 to Feb. 16, 1953, that I last saw the deceased alive on Feby. 15, 1953., and that death occurred at 4:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Clark M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Feby 18 53 | NAME OF CEMETERY OR CREMATORY: Loudon Park | LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG.: 2-17 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: Wm. J. Tickner & Sons Balto 17. Md.

Items 8,9 FilmG153 4/23/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Annapolis

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

STREET ADDRESS (If rural, give location): 198 West Street

3. NAME OF DECEASED (Type or Print): (First) ELIZABETH (Middle) FRANCES (Last) PENCE

4. DATE OF DEATH: (Month) FEBRUARY (Day) 11 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March ~~23~~ 10, 1879

9. AGE last birthday: ~~84~~ 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Newmarket, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs Katherine McCauley Daughter-same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
260X Immediate cause	(a) Arteriosclerotic Heart Disease	Some Yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Generalized Arteriosclerosis	Some yrs.
	DUE TO (c) Diabetes Mellitus	Some yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis — Some yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953, to Feb 11, 1953, that I last saw the deceased alive on Feb 11, 1953, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE: Geo. C Beall — (DEGREE OR TITLE) M. D. — ADDRESS: Annapolis Md — DATE SIGNED: 2-14-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2-14-53

NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Feb. 14, 1953

REGISTRAR'S SIGNATURE: [signature] Reg.

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — **ADDRESS:** Annapolis, Md.

FEB
U. V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01234 26

Reg. Dist. No. 242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. CO. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton — MARYLAND — LENGTH OF STAY (In this place) 2 years — HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY AA. Co — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Broadwater — STREET ADDRESS (If rural, give location) Churchton.

3. NAME OF DECEASED (Type or Print): (First) NORMAN. (Middle) EDWARD. (Last) PERRY

4. DATE OF DEATH: (Month) 2 (Day) 28 (Year) 1953

5. SEX: M. — 6. COLOR OR RACE: W. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married. — 8. DATE OF BIRTH: March 16 1906 — 9. AGE last birthday: 46 yrs. — If under 1 year: Months 11, Days 16 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Body & Fender - Work. — 10b. KIND OF BUSINESS OR INDUSTRY: Automobiles — 11. BIRTHPLACE (State or foreign country): Washington D C. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Lula May Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. Unknown — 17. INFORMANT AND ADDRESS: Elizabeth Shipley 6801 Alton St SE Wash 27 D C

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home. — (CITY OR TOWN) — (COUNTY) A. A. Co — (STATE) Md.

TIME OF INJURY (Month) 2 (Day) 28 (Year) 53 (Hour) 5 p. m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ✓, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: [signature] (Degree or title) M.D. — ADDRESS Annapolis Md — DATE SIGNED 2/28/53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF March 3-1953 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) Suitland — (State) Md.

DATE REC'D BY LOCAL REG. Feb 28 53 — REGISTRAR'S SIGNATURE Edna F. Collins — 24. FUNERAL DIRECTOR Robert A Mattingly — ADDRESS 131-11th St S E Wash D C.

L. B. Dent - cmc

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH 6235

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Rachel (Middle) (Last) Towell
4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 1953
5. SEX: Female | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH: Sept. 25 1901 | 9. AGE last birthday: 51 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): Adams Chapel Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Mackell | 14. MOTHER'S MAIDEN NAME: Ella Parker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS: John Towell - Millersville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 x

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY None | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) 2 (Day) 11 (Year) 53 (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 2/11/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 2-15-53 | NAME OF CEMETERY OR CREMATORY Chews Chapel | LOCATION (City, town, or county) (State) Owensville Md.

DATE REC'D BY LOCAL REG 2-13-53 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR William Case | ADDRESS 138 E. Washington St. Annapolis, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 61236

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Glen Burnie
LENGTH OF STAY (in this place): 6y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Point Pleasant

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Same — COUNTY: Same
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Same

3. NAME OF DECEASED (Type or Print): (First) Hattie (Middle) M. (Last) Reighard

4. DATE OF DEATH: (Month) Feb. (Day) 22 (Year) 1953

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10/7/84

9. AGE last birthday: 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Allick

14. MOTHER'S MAIDEN NAME: Elizabeth Kahline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 218-09-6950

17. INFORMANT & ADDRESS: Charles E Reighard (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331 X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 18 hr

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertension — ?

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/17/53, 19..., to 2/22/53, 19..., that I last saw the deceased alive on 2/21/53, 19..., and that death occurred at 4.45 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Gustave A Bucher M.D. — ADDRESS Glen Burnie, Md. — DATE SIGNED 2/23/53

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 2/26/53 — NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery — LOCATION (City, town, or county) (State) Hutchins Highway Md Co Md

DATE REC'D BY LOCAL REG. 2/24/53 — REGISTRAR'S SIGNATURE L. J. DeWolf

24. FUNERAL DIRECTOR Edward J. Fink — ADDRESS Glen Burnie Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

91237
Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 2yrs. 7 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park
STREET ADDRESS (If rural give location) 108 Zepplial Ave.

3. NAME OF DECEASED: (Type or Print) (First) Ada (Middle) - - - (Last) Rice
4. DATE OF DEATH: (Month) 2 (Day) 21 (Year) 19 53
5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Sept-8-1898
9. AGE last birthday: 54 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -Home -
11. BIRTHPLACE (State or foreign country): Middleburg Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Colvin
14. MOTHER'S MAIDEN NAME: Grace Logan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: ----
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Chronic myocarditis — unknown
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis.
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) -- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from 2/1, 19 53, to 2/21, 19 53, that I last saw the deceased alive on 2/21, 19 53, and that death occurred at 6:10 P.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) Arnold H. Eckert M.D.
ADDRESS Crownsville, Md.
DATE SIGNED 2/22/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2/25/1953
NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.
LOCATION (City, town, or county) (State) Brooklyn Md.
DATE REC'D BY LOCAL REGISTRAR 2/25/53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G Meade,
LENGTH OF STAY (In this place): 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Fort George G Meade,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Florida — COUNTY: Duval
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jacksonville
STREET ADDRESS (If rural, give location): 1121 Logan St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lark	Anthony	Richardson	February	28	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male M	Negro C	never	2/28/53	yrs.				21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
–	–	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Horace Leon Richardson	Dorothy Louise Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no –	–	mothe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Prematurity	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. –

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
–	–	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
–	–	–		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
–			m.		

22. I hereby certify that I attended the deceased from Feb 28, 1953, to Feb 28, 1953, that I last saw the deceased alive on Feb 28, 1953, and that death occurred at 1:38 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Joseph S. Ardinger	MD	26 Reed St.	2/28/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 03	Post Cemetary	Fort George G Meade, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
28 Feb 1953	ARTHUR J [illegible] Capt MSC	JAMES P SPENCER Chaplain (Capt)	Ft Meade Md.

202323210

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01239

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crownsville
LENGTH OF STAY (in this place) 7 yrs. 7 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Wicomico
STATE Maryland — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Siloan
STREET ADDRESS (If rural give location) V

3. NAME OF DECEASED: (Type or Print) (First) Rosalie (Middle) (Last) Rider
4. DATE OF DEATH: (Month) 2 (Day) 13 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Dec. 24?
9. AGE last birthday: 28? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Will Rider
14. MOTHER'S MAIDEN NAME: Annie Chocolate
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) - - - -
16. SOCIAL SECURITY No.: - - - - -
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Pneumonia — 8 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c) DUE TO

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - -
19b. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - -
(CITY OR TOWN) (COUNTY) (STATE) -
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 2/1, 1953, to 2/13, 1953, that I last saw the deceased alive on 2/13, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) Arnold N. Eichert M.D.
ADDRESS Crownsville State Hosp.
DATE SIGNED 2/13/53

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 2/18/53 — NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. — LOCATION (City, town, or county) Crownsville, Maryland (State)
DATE REC'D BY LOCAL REGISTRAR 2-19-53 — REGISTRAR'S SIGNATURE R M Joyce
24. FUNERAL DIRECTOR Arnold N. Eichert, M.D. — ADDRESS Crownsville Maryland

VS-15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 38 yrs. 5½ mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unknown
STREET ADDRESS (If rural give location): Unknown

3. NAME OF DECEASED: (First) Stanley (Middle) (Last) Ringold
4. DATE OF DEATH: (Month) 2 (Day) 19 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 1883?
9. AGE last birthday: 70? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) Cardio-vascular Disease — Interval Between Onset And Death: Unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Generalized Arteriosclerosis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 19 53 to 2/19, 19 53, that I last saw the deceased alive on 2/19, 19 53, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold N. Eichert M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 2/19/53

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF: 3/11/53
NAME OF CEMETERY OR CREMATORY: Crownsville State Hospital
LOCATION (City, town, or county) (State): Crownsville, Md.

DATE REC'D BY LOCAL REGISTRAR: 3-11-53
REGISTRAR'S SIGNATURE: K M Joyce
24. FUNERAL DIRECTOR: Arnold N. Eichert M.D. per
ADDRESS: Crownsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH 6240

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — MARYLAND — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — STREET ADDRESS (If rural, give location) 301 Fourth St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GIUSEPPE		ROSATI	2	6	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last Birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widower	12-31-1865	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Band Master	U. S. Navy Band	Italy	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis Rosati	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	—	Mrs Ida Hayes Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Sclerosis Generalized	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ✓, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	M.	Annapolis Md.	2/7/53.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	2-9-53	St Mary's Cmt	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 8, 1953	[signature] C. Davis D.D.	John W. Gayle Sons	Annapolis Md.

ITEM 22. film C151 2-24-53 L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0124?

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: ANNE ARUNDEL — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: ANNAPOLIS

LENGTH OF STAY (in this place): 17 HOURS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND COUNTY: ANNE ARUNDEL

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS

STREET ADDRESS (If rural, give location): 5 MARYLAND AVENUE

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Charles	Corwin	ROSS	FEB	6	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
MALE	WHITE	MARRIED	AUG 13, 1886	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
CAPTAIN USN	U.S. NAVY	RICHMOND, INDIANA	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William ROSS	Alice FRANCISCO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
YES	WWI & WWII	219 32 2404	HOSPITAL RECORDS - USNH, ANNAPOLIS, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) ARTERIOSCLEROTIC HEART DISEASE (420)	6 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) GENERAL ARTERIOSCLEROSIS (450)	10 yrs
	DUE TO (c)	

420

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☐	HOW DID INJURY OCCUR?
			M.			

22. I hereby certify that I attended the deceased from 5 FEB, 19 53 to 6 FEB, 19 53, that I last saw the deceased alive on 6 FEB, 19 53, and that death occurred at 6:50 A.M. p.m., from the causes and on the date stated above.

SIGNATURE: Edw. Johnson, Jr.

(DEGREE OR TITLE) ADDRESS: E. J. JOHNSON, Jr., LT MC USNR U.S. Naval Hospital, Annapolis, Md.

DATE SIGNED: 2-6-53

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	2-7-53	to	Norfolk, Virginia

DATE REC'D BY LOCAL REG.: Feb. 7, 1953

REGISTRAR'S SIGNATURE: H. E. Johnson

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.

VS-415 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Roland & Arbutus Roads

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach
STREET ADDRESS (If rural, give location): Roland & Arbutus Roads

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	EDWARD	ROWLEY	Feb	10	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Feb. 5, 1884	69 yrs yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Clerk	Record Office City of Baltimore	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward L. Rowley	Amelia V. Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	No	Mrs. Gertrude C. Rowley, Riviera Beach, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Arteriosclerotic Cardio Vascular Disease	5 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Generalized Arteriosclerosis	5 years
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct., 1952, to Feb 10, 1953, that I last saw the deceased alive on 2/10, 1953, and that death occurred at 10:40 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Brady Smith	M D	Riviera Beach, Md.	2/10/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 13, 1953	St. Mary's Cemetery	Hampden, Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		Thomas Donovan	4510 Liberty Heights Ave.

VS-1A-35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

C 243 28
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 4 yrs. 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum Heights
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Milton (Middle) (Last) Sampson

4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1866?

9. AGE last birthday: 87? yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Milton Sampson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk.
(If Yes, give war or dates of service): — — — —

16. SOCIAL SECURITY No.: — — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Generalized Arteriosclerosis — Known to us since adm. 11/9/48

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —

19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1, 1953, to 2/11, 19 53, that I last saw the deceased alive on 2/11, 19 53, and that death occurred at 5:15 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold H. Eibert M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 2/11/53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal
DATE THEREOF: 2/16/53
NAME OF CEMETERY OR CREMATORY: University Med. School
LOCATION (City, town, or county): Balto. City
(State): Md.

DATE REC'D BY LOCAL REGISTRAR: 2/16/53
REGISTRAR'S SIGNATURE: L. M. Joyce - asc
FUNERAL DIRECTOR: Frances A. Hemsley
ADDRESS: 578 W. Biddle St.

FEB 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01244

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 52 ½ West Street

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) (Last) SHEPLER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 10 (Year) 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widower	Sept. 4, 1878	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret	Cigar Mnf.	Europe	USA

13. FATHER'S NAME: Philip Kravinsky

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Mis Isabel Miller same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0

Immediate cause (a) arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yr

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Gen arteriosclerosis.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 53., to Feb 10., 19 53., that I last saw the deceased alive on Feb 10., 19 53., and that death occurred at 12:55 p.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
S. Bernard Wood	M D	Annapolis Md	2/11/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-11-53	Keneseth Israel Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 11, 1953	H. C. Brown Bur	Ben L. Hopping and Son	Annapolis, Md.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01245

CERTIFICATE OF DEATH

Reg. Dist. No. 26

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
LENGTH OF STAY (in this place) 60 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) B. (Last) SMITH

4. DATE OF DEATH (Month) Feb (Day) 28 (Year) 1953

5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH (Month, Day, Year) [illegible] 1876 | 9. AGE last birthday 77 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postmistress | 10b. KIND OF BUSINESS OR INDUSTRY Post Office | 11. BIRTHPLACE (State or foreign country) Nutwell Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm Bunyan Nutwell | 14. MOTHER'S MAIDEN NAME Mary Jane Mumnicle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT AND ADDRESS Mrs Lowell Dixon, Galesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis.

260X (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. diabetes mellitus

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 20, 1950, to Feb 28, 1953, that I last saw the deceased alive on Feb 27, 1953, and that death occurred at 4 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Bowie Lynn Grant M.D. Grady Site Md. Mar 1 '53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 3/2/53 | NAME OF CEMETERY OR CREMATORY Dunbar | LOCATION (City, town, or county) (State) Galesville Md

DATE REC'D BY LOCAL REG. Mar 1-53 | REGISTRAR'S SIGNATURE J. B. Dent | 24. FUNERAL DIRECTOR Hardesty Funeral Home ADDRESS Galesville Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY H. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bambrills | LENGTH OF STAY (in this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md | COUNTY H A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bambrills
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) (Last) Stephens

4. DATE OF DEATH: (Month) Feb (Day) 26 (Year) 1953

5. SEX: fem. | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow | 8. DATE OF BIRTH: Dec. 30 1884 | 9. AGE last birthday: 68 yrs. | IF UNDER 1 YEAR Months 2 Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Halifax Co. Va | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ambrus Stephens | 14. MOTHER'S MAIDEN NAME: Mary Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: Oakly Stephens Bambrills and

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cerebral Accident — 7 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Hypertensive cardio-vascular disease — 10 years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 19 50, to Feb 26, 1953, that I last saw the deceased alive on Feb 19, 1953, and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Edward J Chenault M.D. | Gambrills Md | 2-26-53

23. BURIAL, CREMATION, REMOVAL (Specify) Shipped | DATE THEREOF Feb 28/53 | NAME OF CEMETERY OR CREMATORY Vernon Hill | LOCATION (City, town, or county) Halifax Co. (State) Va.

DATE RECD BY LOCAL REGISTRAR Feb 27, 1953 | REGISTRAR'S SIGNATURE K. M. Jorge | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

March 13 53

VS. A15

Items 9, 10 FilmG151 2/20/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

9 246

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1947 East Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole-Annapolis
STREET ADDRESS (If rural, give location) 1945 East Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Richard	Fowler	Stevens	[illegible] 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	Colored	[illegible]	2/5/1 4	yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
[illegible] Laborer	[illegible] home	[illegible] Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
[illegible] Fowler	[illegible] Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No ------		Elizabeth Fowler-1947 East St. [illegible] Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Cardiac Failure	1 day.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Hypertensive Cardio Vascular Disease	2 yrs.
	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/1, 1953, to 2/9, 1953, that I last saw the deceased alive on 2/9, 1953, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE Theodore O. Jones M.D. (Degree or title) ADDRESS 40 Northwest Street Annapolis, Md. DATE SIGNED 2/10/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/11/53	Forest Hill Cemetery	East St. Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb 11, 1953	[signature] Reg	Ethel L. Hicks-45 Northwest St. Annapolis, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1106 Mitchell St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 1106 Mitchell

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Eugene	T.	Sweeney	2 -	26	1953

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White		7-31-1885	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer	Building	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clifton Sweeney	Alice Mayhew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	215-22-7337	Margaret D. Sweeney - Same as Above

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Sclerosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Sclerosis generalized

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ✓, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ___, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Rumbaugh	MD	Annapolis Md	2/25/53

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2/27/53	St. Mary's	Annapolis, Maryland.

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 26, 1953	[signature]	John H. Taylor & Sons	Annapolis, Md.

VS. A15A

VS. A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02347

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 2 yrs.5mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland
COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1219 E. Biddle Street

3. NAME OF DECEASED (Type or Print): (First) Sibbie (Middle) (Last) Taylor

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: 1892?

9. AGE last birthday: 61? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min. –

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Nowell Tate

14. MOTHER'S MAIDEN NAME: Lucinda Tate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - - - -

16. SOCIAL SECURITY No.: - - - - -

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death: Known to us since 2-1-53

Immediate cause (a) Bronchopneumonia
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - -

19b. MAJOR FINDINGS OF OPERATION - - - - - - - - - - - - - - - - - -

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -
(CITY OR TOWN) (COUNTY) (STATE) - - - - - - - - - - - - - - -
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 2/1, 19 53, to 2/4, 19 53, that I last saw the deceased alive on 2/4, 19 53, and that death occurred at 6:45 a.m.; from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D.
ADDRESS Crownsville, Md.
DATE SIGNED 2/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Feb. 7 1953
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Fredericksburg Va.

DATE REC'D BY LOCAL REGISTRAR 2/5/53

REGISTRAR'S SIGNATURE W. W. Hedrick

24. FUNERAL DIRECTOR Mrs. Robert A. Elliott & Daughter
ADDRESS 1129 N. Caroline St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1248

CERTIFICATE OF DEATH

Reg. Dist. No. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 9 months 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 906 Pine Street

3. NAME OF DECEASED: (Type or Print) (First) Benjamin (Middle) (Last) Tribble

4. DATE OF DEATH: (Month) Feby. (Day) 22 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 2

9. AGE last birthday: 56 2 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dennis Tribble

14. MOTHER'S MAIDEN NAME: Lula Farrel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Crownsville Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

450.0
Immediate cause (a) DUE TO Generalized Arteriosclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

known since early May 20th - 52

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 20th, 1952, to Feby. 22, 1953, that I last saw the deceased alive on Feby. 21st, 1953, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold N. Eichert M.D. ADDRESS Crownsville DATE SIGNED Feby. 22 — 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-27-53 NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. LOCATION (City, town, or county) Balto. (State) City, Md.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Wm. A. Jackson ADDRESS 916 Penna. Ave.

1057

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie. LENGTH OF STAY (In this place) 2 1/2 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 425 Ayrshire Spur. Brooklyn Park.	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Howard	Raymond	Heggie	Feb.	19	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M.	W.	Married.	6/28/1904	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Operator	Victualler	Huntingtown, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Heggie	Emma Hughes.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No.	Unknown	Mrs. Mary A. Heggie (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

42 1/2

Immediate cause (a) Coronary Occlusion — Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
— —	—	Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

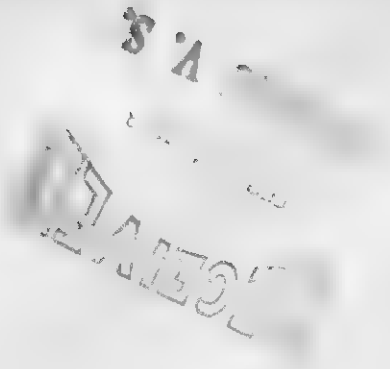
22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Lindsay A. Parker M.D. Medical Examiner	Glen Burnie, Md.	2/19/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 26, 1953	Glen Haven	Glen Burnie	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/21/53	J. DeAlba	W. P. Singleton	Glen Burnie, Md.

VS. A15A



1090 Item 22 Film 3151 3-3-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Severna Park. — LENGTH OF STAY (In this place) 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Manhattan Beach Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY — STATE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS [illegible] (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) [illegible] (Last) Turner
4. DATE OF DEATH: (Month) Feb. (Day) 19 (Year) 1953
5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: 5/24/78
9. AGE Last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy hand.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Bedford, Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Isaac Turner
14. MOTHER'S MAIDEN NAME: Ruth Crosby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) SPANISH AM.
16. SOCIAL SECURITY NO. 214-05-1325
17. INFORMANT AND ADDRESS Mrs. Edith F. Turner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhage - due to — Interval between onset and death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Laceration of right thigh

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Manhattan Beach Rd. — (CITY OR TOWN) P.O. Severna Park. — (COUNTY) A.A. — (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 3/19/53 - 4 p. m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY OCCUR? Laceration - with a power saw.

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
Gustave A. Paulenoff · Deputy Medical Examiner. · Glen Burnie, Md. 2/27/53

21. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 2/24/53 — NAME OF CEMETERY OR CREMATORY Balto. National Cem. — LOCATION (City, town, or county) Balto. (State) Md.
DATE REC'D BY LOCAL REG. 2/24/53 — REGISTRAR'S SIGNATURE L. J. De Alba — 24. FUNERAL DIRECTOR R. V. Singleton — ADDRESS Glen Burnie, Md.

2/24/53 L. J. De Alba

VS-A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0125

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. E. Spencer Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Adams Park

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William	James	Vaughn	2	6	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	Negro	M	4-9-1899	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Myers Coal Yd.	Church Ck., Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mathias Vaughn	Rachel Montgomery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		213-14-5630	Viola Vaughn - Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 days / ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2 Feb, 1953, to 6 Feb, 1953, that I last saw the deceased alive on 6 Feb, 1953, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Edward L. Beck MD	4 Southgate Ave.	2-9-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-10-53	Bowers Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		William Beard	138 W. Washington St. Annapolis, Md.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01252

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G Meade
LENGTH OF STAY (in this place): 3½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE North Carolina — COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Plymouth
STREET ADDRESS (If rural give location): 20 E. Main St. Plymouth, N.C.

3. NAME OF DECEASED: (Type or Print) (First) Sidney (Middle) A (Last) Ward

4. DATE OF DEATH: (Month) February (Day) 12 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 24 Feb 1912

9. AGE last birthday: 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sidney A Ward

14. MOTHER'S MAIDEN NAME: Isolind Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes — (If Yes, give war or dates of service): 1942 to date

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Eula Ward, 1838-A Fort George G Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 6 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pulmonary edema

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 4, 1952 to Feb 12, 1953, that I last saw the deceased alive on Feb 12, 1953, and that death occurred at 0300, from the causes and on the date stated above.

SIGNATURE (Degree or title): Lawrence S Jackson Major MC — ADDRESS: U.S. Army Hosp Ft Meade Md — DATE SIGNED: 12 Feb 53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 12 Feb 53 — NAME OF CEMETERY OR CREMATORY: Grace Church Cemetary — LOCATION (City, town, or county) (State): Plymouth, N.C.

DATE RECD BY LOCAL REGISTRAR: 12 Feb 53 — REGISTRAR'S SIGNATURE: Arthur J Gaynor FH Capt MSC

24. FUNERAL DIRECTOR: J.L. Horner — ADDRESS: Plymouth, N.C.

RECEIVED
FEB 13 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 81253

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 23 yrs. 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 130 East Street
STREET ADDRESS (If rural give location) Frederick, Maryland

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) C. (Last) Washington

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1881?

9. AGE last birthday: 72? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Washington

14. MOTHER'S MAIDEN NAME: Emma Washington

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO.: — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

45

Immediate cause (a) Generalized arteriosclerosis — Interval Between Onset And Death: Unknown.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — —

19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) — — — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1 , 19 53 to 2/4 , 19 53 that I last saw the deceased alive on 2/4 , 19 53 and that death occurred at 4:40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D

ADDRESS Crownsville, Md.

DATE SIGNED 2/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 2/11/53

NAME OF CEMETERY OR CREMATORY University Med School

LOCATION (City, town, or county) Balto County (State) Md

DATE RECD BY LOCAL REGISTRAR 2/11/53

REGISTRAR'S SIGNATURE L. J. Deale M. D.

24. FUNERAL DIRECTOR Frances A Hemsley

ADDRESS 578 N Bridge St

VS. A15

FEB 13 1933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

31254 Reg. Dist. No. 25

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
MARYLAND LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 200 4th Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Same
COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS Same (If rural give location)

3. NAME OF DECEASED: (Type or Print) August (First) (Middle) Weidenhan (Last)

4. DATE OF DEATH: (Month) (Day) (Year) February 15, 53

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 5-12-70

9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR Month Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Processer

10b. KIND OF BUSINESS OR INDUSTRY: Packing House

11. BIRTHPLACE (State or foreign country) Richmond, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Weidenhan

14. MOTHER'S MAIDEN NAME: Sophie Effrig

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Miss Margaret E. Weidenhan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
331X Immediate cause	(a) Cerebral Hemorrhage	12 Hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO	(b) Hypertension	2 yrs.
DUE TO	(c) General Arterio Sclerosis	2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 25, 1953, to Feb. 15, 1953 that I last saw the deceased alive on Feb. 15, 53 and that death occurred at 5:55 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or Title) Winfred A. Faches MD

ADDRESS Glen Burnie, Md.

DATE SIGNED 2-15-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 2/19/53

NAME OF CEMETERY OR CREMATORY New Cathedral

LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR W. W. Meeks & Son

ADDRESS 605 N. Calvert St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01255

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A75

1. PLACE OF DEATH: COUNTY A. A. Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 419 Audrey Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A A Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
STREET ADDRESS (If rural, give location) 419 Audrey Ave

3. NAME OF DECEASED (Type or Print): (First) Bernard (Middle) B. (Last) White

4. DATE OF DEATH: (Month) 2 (Day) 6 (Year) 1953

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married — 8. DATE OF BIRTH: 6/10/1908 — 9. AGE last birthday: 44 yrs. — If under 1 year: Months | Days — If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Book Binder — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Balto. Md. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel White — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO.: 214-05-3828 — 17. INFORMANT AND ADDRESS: Mary White 419 Audrey Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 6 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerotic - C.V.A - Disease — —

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetus Mellitus — —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? Natural

22. I hereby certify that I attended the deceased from Jan 30, 1953, to [illegible], 1953, that I last saw the deceased alive on Jan 29, 1953, and that death occurred at 6:30 P. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Lubin M.D. — 320 Dekoven Ave Baltimore Md — 2/7/53

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State)

Burial — 2/10/1953 — Holy Cross — A. A. Co. Md.

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS

2/9/53 — Rev Edward [illegible] — Flynn & Fleming — 1426 Light St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18256

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Odenton
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Odenton Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton - Md.
STREET ADDRESS (If rural give location) Odenton - Md

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) Beck (Last) White

4. DATE OF DEATH: (Month) 2 (Day) 2 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify):

8. DATE OF BIRTH: 1-14-~~50~~

9. AGE Last birthday: ~~62~~ 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tazwell Ward

14. MOTHER'S MAIDEN NAME: Bell Armstrong

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mady Buckley Crompton Rd. Odenton

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 15 Min

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Coronary Artery Disease — 18 Years

DUE TO (c) Generalized Arterio sclerosis

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ..... 1946, to Feb 2 ., 19 53, that I last saw the deceased alive on Feb 1 1953, and that death occurred at 1 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward J Hewett M.D. Odenton 2-3-53

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify) Burial

DATE THEREOF 2-5-53

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) Arlington (State) Va

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Libby & Jenkins

ADDRESS Norfolk Va

Dupl

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 31257

CERTIFICATE OF DEATH

Reg. Dist. No. 20

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
LENGTH OF STAY (in this place) life.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) MARTHA ELLA (Middle) (Last) WHITE

4. DATE OF DEATH: (Month) Feb. (Day) 8 (Year) 1953

5. SEX: F

6. COLOR OR RACE: Colored.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Dec. 21,

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Galesville Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: STEPHEN WHITE

14. MOTHER'S MAIDEN NAME: ELIZA CROWNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral thrombosis — 36 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerotic Vascular disease

~~DUE TO~~ with

(c) congestive heart failure — 6 mos.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.26., 1953, to 2.8., 1953, that I last saw the deceased alive on 2.7., 1953., and that death occurred at 7.30 A m., from the causes and on the date stated above.

SIGNATURE Bowie Linn Grant — **(DEGREE OR TITLE)** M.D. — **ADDRESS** Shady Side, Md. — **DATE SIGNED** 2.9.53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 2.11.1953

NAME OF CEMETERY OR CREMATORY Galesville Church

LOCATION (City, town, or county) (State) Galesville Md

DATE REC'D BY LOCAL REG. 2/10/53

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR T A Hardesty & Son, Galesville Md — **ADDRESS**

U.S.A.
23 13 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01258
Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 Clay St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 212 Clay St.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) L. (Last) Brute

4. DATE OF DEATH: (Month) 2 (Day) 18 (Year) 1953

5. SEX: female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W.

8. DATE OF BIRTH: 1-2-1855

9. AGE last birthday: 98 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Blackstone

14. MOTHER'S MAIDEN NAME: Nonie Blackstone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: C.H. Bell - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteri — Sclerosis DUE TO

(c)

Interval Between Onset And Death: 1 Year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1953, to Feb 18, 1953, that I last saw the deceased alive on Feb 18, 1953, and that death occurred at 12:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 2/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-21-53 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 21, 1953 REGISTRAR'S SIGNATURE H.W. Worrell

24. FUNERAL DIRECTOR William Reese ADDRESS 108 W. Washington St. Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The source of age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH CORRECT AGE IS ESPECIALLY IMPORTANT. MARGIN RESERVED FOR BINDING IN RESERVED FOR BINDING ING INK. Every item of information should be carefully supplied. T ns: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Anna Marie Whitmore

2. DATE OF DEATH: Feb. 18, 1953

3. PLACE OF DEATH: A ~~Baltimore City~~ Maryland Odenton, Anna Arundel Co.

B FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

c. Length of stay in Baltimore (Yrs. Mos. Days): 2 weeks

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE: Maryland
B COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township.): Keymar
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 8, 1866
9. AGE (In years last birthday): 86 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel S. Bohn
14. MOTHER'S MAIDEN NAME: Rebecca Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. J.C. Whitmore
ADDRESS: Keymar, Maryland

MEDICAL CERTIFICATION

18. 422.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anemia

DUE TO cardio vascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cpl. of kidneys & lungs

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 da
(B) 3 weeks
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Feb 7 *, 1953 to* Feb 18 *, 1953 that I last saw the deceased alive on* Feb 17 *, 1953 and that death occurred at* 5:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr. E. W. Doom M. D.
23B. ADDRESS: 1202 St Paul St
23C. DATE SIGNED: Feb 18 53

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 21, 1953
24C. NAME OF CEMETERY OR CREMATORY: Catholic Cemetery
24D. LOCATION (City, town, or county) (State): Libertytown, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: Mar 7-53
REGISTRAR'S SIGNATURE: [illegible] Deputy
25. FUNERAL DIRECTOR: C.O.Fuss & Son
ADDRESS: Taneytown, Maryland

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

259

21

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 Brins Ct.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; STREET ADDRESS (If rural, give location) 3 O'Brins Ct.

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) (Last) Williams

4. DATE OF DEATH: (Month) 2 (Day) 3 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 7-31-1880

9. AGE last birthday: 72 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Private Cook

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip Modruck

14. MOTHER'S MAIDEN NAME: Sarah Modruck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Christine Brown Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho - Pneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Influenza

(c)

INTERVAL BETWEEN ONSET AND DEATH: Jan 19

481X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953, to Feb 2, 1953, that I last saw the deceased alive on Feb 2, 1953, and that death occurred at 9:45 p m., from the causes and on the date stated above.

SIGNATURE R. Richardson (Degree or Title) MD ADDRESS 110 Clay St Annapolis Md DATE SIGNED 2/5/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 2-5-1953

NAME OF CEMETERY OR CREMATORY Brewer Hill

LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR William Reese

ADDRESS 108 St. Mary's St. Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS: A15 8-51

1. PLACE OF DEATH:

COUNTY Arrundle — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Pasadena — LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pasadena Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena

STREET ADDRESS (If rural, give location): Pasadena

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Ella		Windbush	Feb.	15.	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	Col.	Widow	?	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Domestic	Home	Halifax Co.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Palmer	Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service)	17. INFORMANT & ADDRESS:
No		Mary Coleman Pasadena Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
331X Immediate cause	(a) Cerebral Hemorrhage	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO	(b) Hypertension	15-years
DUE TO	(c) Left hemiplegia	5-years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure — 1-week

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 14 1950, to Feb. 15, 1953, that I last saw the deceased alive on Feb. 14, 1953, and that death occurred at 7.10 P. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D.	Pasadena. Md.	Feb. 15. 1953

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/18/1953	Angle Hill	Halefax Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-17-53		Elroy Wilson	1000 Brantly Ave

1086

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0126

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1B

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Elvaton

LENGTH OF STAY (in this place): 5-4/12 mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Box 174 Rt. 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Elvaton (Millersville P.O.)

STREET ADDRESS (If rural give location): Box 174 Rt 1

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) H. (Last) Wood

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1953

5. SEX: M/F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: July 20, 1887

9. AGE last birthday: 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired): Farmer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Benfield Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elijah W. Wood

14. MOTHER'S MAIDEN NAME: Annie (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Emma A. Wood - Elvaton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 1 hour.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cardio-Vascular Disease. — 5 years.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: None.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1945., to Feb. 18., 1953., that I last saw the deceased alive on Feb 18, 1953, and that death occurred at 12:16 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): James S. Buckingham M.D. — ADDRESS: 108 Central Ave. Glen Burnie Md — DATE SIGNED: Feb 18. 1953.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF: Feb. 20, 1953 — NAME OF CEMETERY OR CREMATORY: Glen Burnie Mem — LOCATION (City, town, or county) (State): Glen Haven

DATE REC'D BY LOCAL REGISTRAR: 2/20/53 — REGISTRAR'S SIGNATURE: J. D. Allen — **24. FUNERAL DIRECTOR** ADDRESS: Richard V. Singleton

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

U1262

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clinton (Millersville P.O.)
LENGTH OF STAY (in this place): 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route #1 Box 178

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clinton (Millersville P.O.)
STREET ADDRESS (If rural, give location): Box 178 - Route #1

3. NAME OF DECEASED (Type or Print): (First) John (Middle) C. (Last) Wood

4. DATE OF DEATH: (Month) Feb 1 (Day) – (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec 2 1868

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Mins

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John M. Wood

14. MOTHER'S MAIDEN NAME: Mary L. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mary L. Wood - Clinton (Millersville P.O.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X **Immediate cause** (a) Lobar Pneumonia — Interval between onset and death: 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cerebral Arteriosclerosis — 1 yr.
(c) Senility — Many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 15, 1952 to Feb 1, 1953 that I last saw the deceased alive on Feb 1, 1953 and that death occurred at 7.45 P. m., from the causes and on the date stated above.

SIGNATURE: Dr. H. Lipsky (Degree or title) M.D. — ADDRESS: Clinton Md — DATE SIGNED: 2-2-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2/4/53 — NAME OF CEMETERY OR CREMATORY: Wood's Family Cemetery — LOCATION (City, town, or county) (State): Clinton Md.

DATE REC'D BY LOCAL REG. 2/3/53 — REGISTRAR'S SIGNATURE: E. J. DeWalt

24. FUNERAL DIRECTOR: H. V. Hengst — ADDRESS: Glen Burnie Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A1

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN N. Laurel
LENGTH OF STAY (in this place) 7 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington. COUNTY D. C
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.
STREET ADDRESS (If rural, give location) 1323 Clifton St. N.E.

3. NAME OF DECEASED (Type or Print) (First) David (Middle) Edwin (Last) Woods
4. DATE OF DEATH (Month) 2 (Day) 11 (Year) 1953
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify) Single
8. DATE OF BIRTH 10-12-1949
9. AGE last birthday 3 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) In fant
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) Washington. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hermon F. Wood
14. MOTHER'S MAIDEN NAME UNKNOWN.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AND ADDRESS Records. D.T.S- Laurel. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Tuberculosis — 56 Hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Heart Valves congenital deformed — life
(c) Epilepsy — 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental Deficiency - Microcephalic Idiot. — Life -

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16- 1952, to 2-11- 1953, that I last saw the deceased alive on 2-10- 1953, and that death occurred at 3- P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
B. Schudt M.D. Medical Officer District Tr. School Laurel Md. 2/11/53.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Feb. 12-53 NAME OF CEMETERY OR CREMATORY D.T. School LOCATION (City, town, or county) Laurel (State) Md

DATE REC'D BY LOCAL REG. Feb 11-53 REGISTRAR'S SIGNATURE Clara Rathup
24. FUNERAL DIRECTOR Raymond Jones ADDRESS 1 Talbot Laurel Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1264 2 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15 8-53

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville

LENGTH OF STAY (in this place): 3 yrs. 1 mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Baltimore City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City

STREET ADDRESS (If rural, give location): 824 N. Calhoun St.,

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Irene	Annie	Young	2	1	53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	Negro	Married	1/17/94	59yrs. yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework	Unk.	Maryland	U. S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Nick Briscoll	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unk. — — — —	— — — —	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

OCA

Immediate cause — (a) Chronic Myocarditis

DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Syphilis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
— — —	— — — — — — — — — — — — — — — — — —	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
— — — — — —	— — — —	— — — — — — — — — — — — — — — —		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— — — — — —			M.		— — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 12/16 19 49, to 2/1 19 53, that I last saw the deceased alive on 2/1 19 53 and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE: Nick Mancuso M.D. — (DEGREE OR TITLE) — ADDRESS: Crownsville, Md. — DATE SIGNED: 2/1/53

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 4 53	Mt. Calvary Cem.	Balto. County	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/2/53	A. W. Hahn M.D.	Mrs. Alt. G. Ellis & Daughter	1129 N. Carrollton St

Item 9 FilmG152 3/19/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801265 28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville; LENGTH OF STAY (in this place) 4 yrs.9 mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
HOSPITAL OR INSTITUTION OR STREET ADDRESS CrownsvilleState Hospital	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Nealie (Middle) (Last) Young

4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 19 53

5. SEX: Female | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: | 9. AGE last birthday: 62? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Let Hugh Dandy

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) - - - -

16. SOCIAL SECURITY No.: - - - -

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 491X

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Senile harasm and generalized arteriosclerosis — Known to us since 5/10/48

19a. DATE OF OPERATION: - - - - - -

19b. MAJOR FINDINGS OF OPERATION - - - - -

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - | (CITY OR TOWN) - - - (COUNTY) - - - (STATE) - - -

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? - - - - - -

22. I hereby certify that I attended the deceased from 2-6, 1953, to 2-11, 1953 that I last saw the deceased alive on 2-11, 1953, and that death occurred at 11:12 am, from the causes and on the date stated above.

SIGNATURE Faye W. Allen (Degree or title) M.D. ADDRESS 10 Carroll St DATE SIGNED 2-11-53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal | DATE THEREOF 2/16/53 | NAME OF CEMETERY OR CREMATORY University Med School | LOCATION (City, town, or county) Balto City (State) Md

DATE REC'D BY LOCAL REGISTRAR 2/16/53 | REGISTRAR'S SIGNATURE L. J. DeAlba | 24. FUNERAL DIRECTOR Frances A Hemsley ADDRESS 578 W Biddle

K. M. Joyce-cmc

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01266

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; HOSPITAL OR INSTITUTION OR STREET ADDRESS 135 Gloucester St.; MARYLAND; LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 135 Gloucester St.

3. NAME OF DECEASED (Type or Print): (First) J. (Middle) Henry (Last) Zeller

4. DATE OF DEATH: (Month) 2 (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)

8. DATE OF BIRTH: Nov. 17, 1862

9. AGE last birthday: 90 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Court Crier

10b. KIND OF BUSINESS OR INDUSTRY: County

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Zeller

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Margaret G. Zeller - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Myocardial Infarction — Interval Between Onset and Death: 1 day

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, Generalized — 1 Yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 1953 to 2-13-, 1953 that I last saw the deceased alive on 2-13-, 1953, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE: James A. Martin (Degree or title) MD ADDRESS Annapolis, Md. DATE SIGNED 2-15-53

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF 2-16-1953 | NAME OF CEMETERY OR CREMATORY St. Mary's | LOCATION (City, town, or county) Annapolis | (State) Md.

DATE REC'D BY LOCAL REG. Feb. 16, 1953 | REGISTRAR'S SIGNATURE H. O. Brown B.W. | 24. FUNERAL DIRECTOR John M. Taylor & Son | ADDRESS Annapolis, Md.

RECEIVED
FEB 18 1953
BUREAU V. S.